

Official use only- Region _____

**New Hampshire Department of Safety
Bureau of Emergency Medical Services**

Automated External Defibrillation Request Form

Entity for which the unit is being requested: _____

Type of Entity: Business, Municipality, Store, other please specify _____

Contact person and title within the entity: _____

Mailing Address: _____

Person requesting: _____
(Name) (Phone) (E-mail)

Number of AEDs requested: _____

Reason for request: _____

Does the organization currently have an AED or Cardiac Monitor? YES / NO

Is the entity able to accept financial responsibility for the AED? YES / NO
(i.e. Maintenance, extra pads, batteries)

Street address of AED _____

City/Town _____ State _____ Zip _____

Where, at the above location, would the AED be stored? _____

Is there anyone currently trained in CPR/AED? YES / NO

Number of AED Providers _____

Signature: _____ Date: _____

Please return to:

Department of Safety
Division of Fire Standards and Training
Bureau of Emergency Medical Services
33 Hazen Drive Concord NH, 03305
or Fax to: 603-271-4567